

Item 9 on:

FILM No. G 133 MAY 21 1951

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

03131

Reg. Dist. No. 350

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write nearest town) TOWN <u>Pocomoke City Rural</u>		CITY (If outside corporate limits, write nearest town) TOWN <u>Pocomoke City (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Levin</u> <u>Burke</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>28</u> <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH <u>4/26/37</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life or if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>14</u> yrs. If under 1 year Months Days If under 24 hrs Hours Min.
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Garrett Burke</u>		14. MOTHER'S MAIDEN NAME <u>Mary Cunningham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Rurwood Burke (son)</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>Cornary Disease</u>			INTERVAL BETWEEN ONSET AND DEATH
2. IMMEDIATE cause (a).....			
3. Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b).....			
(c).....			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>J. H. E. [illegible]</u>		DATE SIGNED <u>3/28/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <u>3/21/51</u>		<u>Burke Cemetery</u>	
LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>			
24. FUNERAL DIRECTOR REG. <u>March 31, 1951</u>		ADDRESS <u>Shirley H. Watson (Pocomoke Md.)</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

950306

RECEIVED
APR 4 1951
BUREAU Y. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03132

Reg. Dist. No. 351

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill Rural #2</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill Rural #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Laurence</u>	(Middle) <u>B.</u>	(Last) <u>Butler</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>16</u>	(Year) <u>1957</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb. 8, 1893</u>
9. AGE last birthday <u>58 1/2</u> mos. 8 days		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Princess Anne, Ind.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Sidney Butler</u>		14. MOTHER'S MAIDEN NAME <u>Mary Packard</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>214-18-4235</u>	
17. INFORMANT <u>Mrs. Martha E. Butler, Snow Hill, Ind. R2</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) <u>Acute Coronary Occlusion</u>	<u>1 hr.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) <u>Hypertensive Cardiovascular Disease</u>	<u>10 yrs.</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb......, 1949, to March 16....., 1951....., that I last saw the deceased alive on March 12....., 1951..... and that death occurred at 7:30 P.....m., from the causes and on the date stated above.

SIGNATURE Robert LaMar M.D. ADDRESS Snow Hill. DATE SIGNED 3-17-51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>March 18, 1951</u>	<u>Perry Hawkins</u>	<u>Princess Anne</u>	<u>Ind</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/17/51</u>	<u>LeRoy Smith</u>	<u>Elmer C. Harris</u>	<u>Snow Hill, Ind</u>	

100105

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

03133

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 357

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
TOWN <u>Berlin</u>		TOWN <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>West St.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Severell</u>	(Middle) <u>S</u>	(Last) <u>Cropper</u>
4. DATE OF DEATH	(Month) <u>Mar.</u>	(Day) <u>21</u>	(Year) <u>1957</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar 3, 1863</u>
9. AGE last birthday <u>88</u> yrs.	If under 1 year Months	If under 24 hrs. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Newark Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Samuel Cropper</u>		14. MOTHER'S MAIDEN NAME <u>Letitia Davis</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mr. Seidig Cropper Newark Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cerebral Hemorrhage

Antecedent cause(s)

(b)

Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Senility

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3-16, 1957, to 3-21, 1957, that I last saw the deceasedalive on 3-21, 1957, and that death occurred at 11 P m., from the causes and on the date stated above.

SIGNATURE:

(Degree or title)

ADDRESS

DATE SIGNED

Clifford E. Schott MD. Berlin Md (Worcester)

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

3/23/57LeRoy SmithJames A. Buehler Berlin Md

100105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

03134

1. PLACE OF DEATH COUNTY Worcester		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pocomoke		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Pocomoke	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6th St.		STREET ADDRESS (If rural, give location) 6th St.	
3. NAME OF DECEASED (Type or Print) WILLIAM		4. DATE OF DEATH March 10, 1951	
(First) (Middle) (Last) DICKERSON			
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widower	8. DATE OF BIRTH July 4, 1887
		9. AGE last birthday 63 yrs.	10. If under 1 year 11. If under 24 hrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Gardening	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME John Dickerson		14. MOTHER'S MAIDEN NAME Sallie Copes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No	
17. INFORMANT AND ADDRESS Elizabeth Collins, Pocomoke, Md.			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Cerebral Hemorrhage.			3 days
Antecedent cause(s) (b) Arterio-sclerotic Cardio-Vasc. Disease 10 Yrs.			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Senility.			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 5, 1951, to March 10, 1951, that I last saw the deceased alive on March 10, 1951, and that death occurred at 8 A.M., from the causes and on the date stated above.

SIGNATURE Louis S. Cleveland (Degree or title) ADDRESS 24. D. Pocomoke City, Md. DATE SIGNED 3/12/51

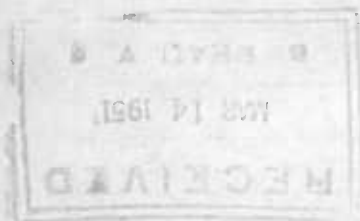
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/12/51	NAME OF CEMETERY OR CREMATORY Hall's Hill Cemetery	LOCATION (City, town, or county) Pocomoke, Md. (State)
DATE REC'D BY LOCAL REG. March 12, 1951	REGISTRAR'S SIGNATURE Anne E. White	24. FUNERAL DIRECTOR Henry H. Watson, Pocomoke, Md. ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

820105



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03135

Reg. Dist. No. 351

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Newark Rural #1</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Newark Rural #1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Baby Boy</u> (<u>Dryden</u>)		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>26</u> <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>March 26, 1951</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min. <u>13</u> <u>0</u>
13. FATHER'S NAME <u>Robert S. Dryden</u>		14. MOTHER'S MAIDEN NAME <u>Grace V. Beauchamp</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs. Robert S. Dryden, Newark, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Prematurity (wt. 1^{lb} 3^{3/4} oz)

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3-26-1951, to 3-26-1951, that I last saw the deceasedalive on 3-26-1951, and that death occurred at 9:00 P.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

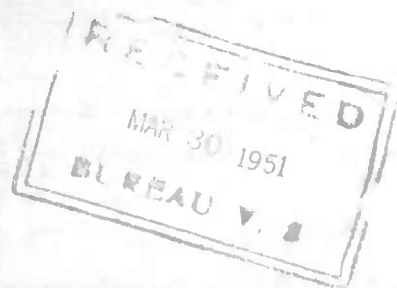
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/27/51</u>	<u>Bates Methodist</u>	<u>Snow Hill, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/27/51</u>	<u>Reley Smith</u>	<u>Walter P. Smith, Jr.</u>	<u>Snow Hill, Md.</u>	

103261251260

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

03139

1. PLACE OF DEATH COUNTY Worcester		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke		CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cedar St.		STREET ADDRESS (If rural, give location) Cedar St.	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
	JOSEPH	R.	FORD
4. DATE OF DEATH	(Month)	(Day)	(Year)
	March	28	1951
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
Male	White	Married	June 8, 1875
9. AGE last birthday	If under 1 year	If under 24 hrs.	
75 yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY
Carpenter	Building	Maryland	US
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Edward T. Ford		Sarah E. Corwsell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
No		None	
17. INFORMANT AND ADDRESS			
Mrs. Bertie Ford, Pocomoke, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

163X Immediate cause

(a)

Cancer of the Lung**Unknown**

Antecedent cause(s)

47d

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Regenerative Heart Disease

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Feb. 1949**, to **Mar. 28, 1951**, that I last saw the deceasedalive on **Mar. 27, 1951**, and that death occurred at **11:00 a.m.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Charles W. Trader**MD****Pocomoke City, Md.****4/2/51**

23. BURIAL CREMATION

REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

April 2, 1951**Anne E. White****Henry H. Watson, Pocomoke, Md.**

510246

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 4 1951
BUREAU 6

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

03136

Reg. Dist. No. 351

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Wor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Newark - Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Newark - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>Henry</u> (Middle) <u>Foreman</u> (Last)		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1977</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/15/30</u>
9. AGE last birthday <u>25</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Poultry Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Henry Foreman, Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> <u>in</u> <u>World War II</u>		16. SOCIAL SECURITY No. <u>202-18-2193</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Thelma Foreman, Newark, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Levopropound fracture skull - frontal</u>		<u>Instant</u>	
Antecedent cause(s) (b) <u>Fracture of neck</u>		<u>Instant</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Head on collision car & truck 45 Hwy 11/3</u>		<u>11/3</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>Collision auto - truck - MP 24.20</u>			
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office, etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3</u> <u>31</u> <u>51</u> <u>11</u> <u>50</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
HOW DID INJURY OCCUR? <u>Collision auto - truck 45 Hwy 11/3</u>			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>J. S. Vaisoch, M.D.</u>		DATE SIGNED <u>3/31/77</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>4-4-51</u>	
NAME OF CEMETERY OR CREMATORY <u>Cedar Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Newark, Worcester Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>4/4/51</u>		24. FUNERAL DIRECTOR <u>James B. Dashiell, Salisbury, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

690'609



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03137 355

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worship</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>RFD # 2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>GEORGE</u> (Middle) <u>ROBERT</u> (Last) <u>GARCIA</u>	4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>8</u> (Year) <u>1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>4/23/1884</u>
9. AGE last birthday <u>68</u> yrs. If under 1 year Months <u>10</u> Days <u>15</u> If under 24 hrs. Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Race track</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Antone Garcia</u>	
14. MOTHER'S MAIDEN NAME <u>Mary Love</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>Mrs. H. R. Garcia Berlin Md # 2</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Coronary Occlusion</u>		<u>36 hrs.</u>
Antecedent cause(s) (b) <u>Hypertension & Coronary sclerosis</u>		<u>5 yrs.</u>
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 Mar., 1951, to 8 Mar., 1951, that I last saw the deceased alive on 7 Mar., 1951, and that death occurred at 3 P. m., from the causes and on the date stated above.

SIGNATURE <u>H. L. Thomas</u>	(Degree or title) <u>MD</u>	ADDRESS <u>Ocean City, Md.</u>	DATE SIGNED <u>10 Mar 51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/12/51</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md</u>
DATE REC'D BY LOCAL REG. <u>3/10/51</u>	REGISTRAR'S SIGNATURE <u>Helen F. Hayward</u>	24. FUNERAL DIRECTOR <u>Anna A. Burby</u>	ADDRESS <u>Berlin Md</u>

970 859

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Q-1238



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03138
Reg. Dist. No. 353

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bishopville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Bishopville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS <u>Rural.</u>	
3. NAME OF DECEASED (Type or Print) <u>William J. Halloway</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>14</u> (Year) <u>1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Dec. 25, 1890</u>
9. AGE last birthday <u>70</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>operated his own farm</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Paul Halloway</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Cathell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Dorley J. Selby Bishop Md. R 74</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Cerebro vascular accident</u>				<u>2 weeks</u>	
Antecedent cause(s) (b) <u>Hypertensive cardiovascular dis.</u>				<u>10 years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from July 1950, to March 14, 1951, that I last saw the deceased alive on March 14, 1951, and that death occurred at 8:30 P.M., from the causes and on the date stated above.

SIGNATURE <u>William H. Young M.D.</u>		ADDRESS <u>Selbyville, Del</u>		DATE SIGNED <u>Mar 15</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3/16/51</u>		NAME OF CEMETERY OR CREMATORY <u>I.O.O.F.</u>	
LOCATION (city, town, or county) <u>Bishopville Md.</u>		24. FUNERAL DIRECTOR <u>M. Kasha Nation</u>		ADDRESS <u>Selbyville, Del.</u>	
DATE RECD BY LOCAL REG <u>3/15/51</u>		REGISTRAR'S SIGNATURE <u>Mrs. Roy Bergcy</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

03140

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Norris</u> (First) <u>Lynn</u> (Middle) <u>King</u> (Last)		4. DATE OF DEATH <u>March 24</u> 19 <u>51</u> (Month) (Day) (Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Feb 9/1894</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clothing salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>57</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>John Francis King</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If year, give war or dates of service) <u>World War</u>		14. MOTHER'S MAIDEN NAME <u>Sarah E. Gibbons</u>	
16. SOCIAL SECURITY No. <u>22-0-12-2263</u>		17. INFORMANT AND ADDRESS <u>Mrs Myrtle Stant, Pocomoke Md</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
Immediate cause (a) <u>Pulmonary Tuberculosis</u>		
Antecedent cause(s) (b) <u>13b</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 17, 1951, to Mar 24, 1951, that I last saw the deceased alive on Mar 24, 1951, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE Charles W. Trader (Degree or title) MD ADDRESS Pocomoke City, Md. DATE SIGNED Mar 26, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/27/51</u>	NAME OF CEMETERY OR CREMATORY <u>Salina M. C. Cemetery</u>	LOCATION (City, town, or county) <u>Pocomoke Md</u> (State)
DATE REC'D BY LOCAL REG. <u>March 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Anne E. White</u>	24. FUNERAL DIRECTOR <u>Harry S. Watson</u>	ADDRESS

490656

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03141

CERTIFICATE OF DEATH

Reg. Dist. No. 354

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Stockton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u> (Middle) <u>THOMAS</u> (Last) <u>MANUEL</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Mar. 28 1951</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Mar. ? 1874</u>
9. AGE last birthday <u>77</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>Richard Holland</u>	14. MOTHER'S MAIDEN NAME <u>Louise ? (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)	16. SOCIAL SECURITY No. <u>4</u>	17. INFORMANT AND ADDRESS <u>Ivory Bennett, Stockton Ind.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cachexia and inanition</u>			<u>2 wks</u>
Antecedent cause(s) (b) <u>Metastatic Carcinoma of Liver (origin undetermined)</u>			<u>3 mos</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>2-12-51</u>	19b. MAJOR FINDINGS OF OPERATION <u>Punch Biopsy</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from MAY 15, 1951, to MARCH 28, 1951, that I last saw the deceased alive on MARCH 25, 1951 and that death occurred at 10:00 A.M., from the causes and on the date stated above.

SIGNATURE <u>Robert B. Lamer</u> M.D.	ADDRESS <u>Snod Hill</u>	DATE SIGNED <u>3-31-51</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE <u>Mar. 31, 1951</u>	NAME OF CEMETERY OR CREMATORY <u>Home Beneficial Cemetery</u>
LOCATION (City, town, or county) <u>Stockton</u>	(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 31, 1951</u>	REGISTRAR'S SIGNATURE <u>Mary M. Taylor</u>	24. FUNERAL DIRECTOR <u>Ivory Bennett</u>
		ADDRESS <u>9700 Stockton Ind</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
APR 5 1951
BUREAU Y. O.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

03142

Reg. Dist. No. 350

1. PLACE OF DEATH- COUNTY Worcester STATE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Worcester	
CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke		CITY (If outside corporate limits, write RURAL and give nearest town) Pocomoke	
HOSPITAL OR INSTITUTION OR STREET ADDRESS U S Highway 13		STREET ADDRESS (If rural give location) RFD #3	
3. NAME OF DECEASED (Type or Print)	(First) MARTIN (Middle) LEE (Last) MANUEL	4. DATE OF DEATH (Month) March (Day) 10 (Year) 1951	
5. SEX Male	6. COLOR OR RACE Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 1933
9. AGE last birthday 17 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY US	
13. FATHER'S NAME Clifford Manuel		14. MOTHER'S MAIDEN NAME Zola Brown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. None	
17. INFORMANT Clifford Manuel, Pocomoke, Md.			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause Skull fractures + Massive hemorrhage		Immediate	
Antecedent cause(s) Disease or condition(s), if any, giving rise to the above cause stating the underlying cause last Head trauma collection with long term			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Dumex had been diving			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE of home, farm, factory, street, etc. (Specify) 5 miles south of Pocomoke Worcester Md	(CITY OR TOWN) (COUNTY) (STATE)	
TIME OF INJURY March 10 1951	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? collided with a large	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> Thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> SIGNATURE J. E. Antonsen, Dep. Med. Examiner, Pocomoke City Md ADDRESS Pocomoke City Md DATE SIGNED 3/10/51			
23. BURIAL, CREMATION OR REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
Burial	3/12/51	Mt. Hope Cemetery	RFD 3, Pocomoke, Md.
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
March 12 1951	Anne E. White	Henry H. Watson, Pocomoke, Md.	

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

940 WV

RECEIVED
MAR 14 1961
RUEBAY A.S.

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 350

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>600 Church St</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u>	(Middle) <u>Ed</u>	(Last) <u>Mason</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH <u>Dec 21 - 1879</u>
9. AGE last birthday <u>71</u> yrs.		10. DATE OF DEATH <u>March 28</u> 19 <u>51</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Mason</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Collins</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Adam Francis Mason Son</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>Coronary Disease</u>			
Antecedent cause(s) (b) <u>Generalized Atherosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION <u>18 days he had worked for 5 years</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office bldg., etc.)	
CAUSE OF DEATH		INJURY <u>On Highway</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
<u>Pocomoke</u>		<u>Worcester Md</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>Dr. W. E. Anthony</u>		DATE SIGNED <u>3/28/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF <u>4/1/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>		LOCATION (City, town, or county) (State) <u>Rural Pocomoke Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Anne E. White</u>		24. FUNERAL DIRECTOR <u>Henry H. Watson</u>	
REG. <u>March 31, 1951</u>		ADDRESS <u>Pocomoke Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EDOLY

OF COW

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

03144

(1894)

Reg. Dist. No.

355

1. PLACE OF DEATH - COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN <u>Worcester</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> TOWN <u>Worcester</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>at home</u>		STREET ADDRESS (If rural, give location) <u>Deer farm</u>	
3. NAME OF DECEASED (First) <u>Wm</u> (Middle) <u>Ralph</u> (Last) <u>Mitchell</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>1951</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>9/18/1884</u> 9. AGE last birthday <u>56</u> yrs. Months <u>5</u> Days <u>16</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer General</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Worcester</u>	
11. BIRTHPLACE (State or foreign country) <u>Worcester, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Henry M Mitchell</u>		14. MOTHER'S MAIDEN NAME <u>Annie Bell Rock</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Raymond Mitchell</u>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH <u>very short</u>	
420.1 Immediate cause (a) <u>(Probably) Coronary Disease</u>			
94a Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>History of Heart attacks</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death <u>History of having been Gassed in World War I</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>Home</u> INJURY <u>None</u> (CITY OR TOWN) <u>Berlin</u> (COUNTY) <u>Worcester</u> (STATE) <u>MD</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/4/51</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? <u>No injury</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>N. E. Astorius</u>		ADDRESS <u>Pocomoke City Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/6/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		LOCATION (City, town, or county) <u>Berlin</u> (State) <u>MD</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>3/6/51</u> <u>Helen F Hayward</u>		4. FUNERAL DIRECTOR <u>Anna A. Buehler</u> ADDRESS <u>Berlin Md</u>	

100105



MARYLAND STATE DEPARTMENT OF HEALTH

03145

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 955

1. PLACE OF DEATH COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>Maryland</i> COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>		LENGTH OF STAY (In this place) <i>15</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cambridge</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <i>Road</i>	
3. NAME OF DECEASED (Type or Print)		(First) <i>Peter</i> (Middle) <i>Edward</i> (Last) <i>Mumford</i>		4. DATE OF DEATH (Month) <i>March</i> (Day) <i>16</i> (Year) <i>1951</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Married</i>	8. DATE OF BIRTH <i>Feb 9 - 1891</i>	9. AGE last birthday <i>60</i> yrs.	If under 1 year Months Days If under 24 hrs Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <i>Miller</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
13. FATHER'S NAME <i>Isaac Mumford</i>		14. MOTHER'S MAIDEN NAME <i>German</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>213-16-8559</i>		17. INFORMANT AND ADDRESS <i>Ernie W. Mumford - Bushy Pt</i>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause <i>(a) Subarachnoid Hemorrhage</i> INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>					
Antecedent cause(s) <i>(b) Hemorrhage into 3rd + 4th Ventrals</i> <i>2 days</i>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>(c) Retroperitoneal hemorrhage Rt</i> <i>1 month</i>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION <i>None</i>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. EXTERNAL CAUSE WAS (a) PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) <i>Mill</i>		(CITY OR TOWN) <i>Wicomico</i> (COUNTY) <i>Md.</i> (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>Feb 25 1951</i> m.		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR? <i>While carrying a heavy door with another man who dropped his end</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE <i>Dr. E. S. Sutorius</i>		(Degree or title)		ADDRESS <i>Laurens City, Md.</i> DATE SIGNED <i>3/17/51</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>March 19, 1951</i>		NAME OF CEMETERY OR CREMATORY <i>Whaleyville Md.</i> (State)	
DATE REC'D BY LOCAL REG. <i>Mar 19, 51</i>		REGISTRAR'S SIGNATURE <i>Helen F. Hayward</i>		24. FUNERAL DIRECTOR <i>Marsha Watson</i> ADDRESS <i>Sellyville, Del.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 24 1961
U. S. DEPT. OF JUSTICE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 355

03146

1. PLACE OF DEATH- COUNTY <i>Berlin Worcester</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <i>Maryland</i> COUNTY <i>Worcester</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>+</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Berlin</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <i>Williams St</i>	
3. NAME OF DECEASED (Type or Print) <i>Lorah</i> (First) <i>Blvin</i> (Middle) <i>Richardson</i> (Last)		4. DATE OF DEATH (Month) <i>March</i> (Day) <i>30</i> (Year) <i>1951</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <i>married</i>	8. DATE OF BIRTH <i>Dec. 14, 1879</i>
9. AGE last birthday <i>71</i> yrs.		10. DATE last birthday <i>March 30</i>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Retired Contractor</i>		11b. KIND OF BUSINESS OR INDUSTRY <i>Building Frames</i>	
12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>		13. BIRTHPLACE (State or foreign country) <i>Willards, Md.</i>	
14. FATHER'S NAME <i>Peter Sidney Richardson</i>		15. MOTHER'S MAIDEN NAME <i>Ellen Parsons</i>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <i>SW</i>	
18. INFORMANT AND ADDRESS <i>Mrs. L.A. Richardson, Berlin Md</i>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause <i>Cerebral Apoplexy</i>			
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <i>Hypertension</i>			
(c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1-1-</i> , 19 <i>48</i> to <i>3-30</i> , 19 <i>51</i> , that I last saw the deceased alive on <i>3-29</i> , 19 <i>51</i> , and that death occurred at <i>7:00 PM</i> m., from the causes and on the date stated above.			
SIGNATURE <i>Clifford E. DeLoat</i>		ADDRESS <i>Md Berlin</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>burial</i>		DATE THEREOF <i>4/1/51</i>	
NAME OF CEMETERY OR CREMATORY <i>Willard</i>		LOCATION (City, town, or county) (State) <i>Willards Md</i>	
DATE REC'D BY LOCAL REG. <i>4/1/51</i>		REGISTRAR'S SIGNATURE <i>Helen F Hayward</i>	
24. FUNERAL DIRECTOR <i>Anna A Burbage</i>		ADDRESS <i>Berlin Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

290246



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

03147

Reg. Dist. No. 350

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City Md</u> TOWN <u>Pocomoke City Md</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Watson's Funeral Parlor</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Worcester</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Gardnetts (Rural)</u> TOWN <u>Gardnetts (Rural)</u> STREET ADDRESS <u>Rural - 2 miles from Gardnetts</u>	
3. NAME OF DECEASED (First) <u>Wm</u> (Middle) <u>Edward Curtis</u> (Last) <u>Selby</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>15</u> (Year) <u>1951</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>April 15 - 1889</u> <u>61</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agiculture</u>	
11. FATHER'S NAME <u>Jack Selby</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. MOTHER'S NAME <u>Ellen Payne</u>		14. BIRTHPLACE (State or foreign country) <u>Pocomoke City Md</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Widow Wilson Selby - Son</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause (a) <u>976x Suicide by firearm (Bullet in at temple, bursting brain)</u> Antecedent cause(s) (b) <u>164c Dependent on loss</u> Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Dependent on loss</u>			
2. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/>		PLACE (Home, farm, factory, street, office, hdq., etc.) <u>Worcester Md</u> INJURY <u>Shooting</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 15 - 1951</u> <u>8</u> m.		HOW DID INJURY OCCUR? <u>Shot himself with his own rifle</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: <input checked="" type="checkbox"/> natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Dr. M. E. Aptons - J. M. E. M. E.</u>		ADDRESS <u>Pocomoke City Md</u> DATE SIGNED <u>3/15/51</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>3/18/51</u>	
NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Baptist</u>		LOCATION (City, town, or county) (State) <u>Pocomoke City, Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 17, 1951</u>		24. FUNERAL DIRECTOR <u>Henry H. Watson, Pocomoke City</u>	

100105 Md.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 351

03148

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill Rural #2</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Snow Hill Rural #2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>Mary</u> (Middle) <u>H.</u> (Last) <u>Taylor</u>		(Month) <u>March</u> (Day) <u>2</u> (Year) <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Dec. 18 - 1964</u>
9. AGE last birthday <u>86 2/3</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	11. BIRTHPLACE (State or foreign country) <u>Snow Hill</u>
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>James Hudson</u>	
14. MOTHER'S MAIDEN NAME <u>Eric Selby</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT AND ADDRESS <u>Mrs. Richard Taylor Taylor, Snow Hill, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause		(a) <u>Acute Pulmonary Edema</u>	
442 X Antecedent cause(s)		(b) <u>Hypertensive Cardiovascular Renal Disease</u>	
131a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) <u>10 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE) <u>Snow Hill Worcester Md.</u>	
22. I hereby certify that I attended the deceased from <u>Sept.</u> , 19 <u>50</u> , to <u>Mar. 2</u> , 19 <u>51</u> , that I last saw the deceased alive on <u>March 1</u> , 19 <u>51</u> , and that death occurred at <u>10:45 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Robert L. La Mar MD</u>		ADDRESS <u>Snow Hill</u>	
DATE SIGNED <u>3-3-51</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE	
<u>Burial</u>		<u>March 4/51</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Taylor Cemetery</u>		<u>Snow Hill Md</u>	
DATE REC'D BY LOCAL REG.		REGISTER'S SIGNATURE	
<u>3/3/51</u>		<u>LeRoy Smith</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Walter C. Harris</u>		<u>Snow Hill, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAY 8 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

03149

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

1. PLACE OF DEATH COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke R.A.D.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural, Pocomoke Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Sallie</u> (First) <u>Catherine</u> (Middle) <u>Taylor</u> (Last)		4. DATE OF DEATH <u>March 24</u> 19 <u>51</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct 13, 1867</u>
9. AGE last birthday <u>83</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. FATHER'S NAME <u>Isaiah Justice</u>		12. MOTHER'S MAIDEN NAME <u>Unknown</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		14. SOCIAL SECURITY NO.	
15. INFORMANT AND ADDRESS <u>Littleton Taylor, Delmar Md.</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>			<u>Undetermined</u>
940 Antecedent cause(s) (b) <u>Arteriosclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility and Malnutrition</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Jan. 21, 1951, to Mar. 24, 1951, that I last saw the deceased alive on Mar. 23, 1951, and that death occurred at 5:58 a.m., from the causes and on the date stated above.

SIGNATURE Charles W. Trader, MD ADDRESS Pocomoke City, Md. DATE SIGNED Mar. 26, 1951

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/26/51</u>	NAME OF CEMETERY OR CREMATORY <u>Nelson Cemetery</u>	LOCATION (City, town, or county) <u>Rural Pocomoke Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>March 26, 1951</u>	REGISTRAR'S SIGNATURE <u>Anne E. White</u>	24. FUNERAL DIRECTOR <u>Henry S. Watson</u>	ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 350

03150

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Pocomoke</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel St.</u>		STREET ADDRESS <u>Laurel St.</u> (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>ALICE</u>	(Middle) <u>ELIZABETH</u>	(Last) <u>VINCENT</u>
4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>28</u> , (Year) <u>1951</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 24, 1869</u>
9. AGE last birthday <u>81</u> yrs.	If under 1 year Months	If under 24 hrs. Days	If under 24 hrs. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>US</u>		13. FATHER'S NAME <u>Richard T. Dixon</u>	
14. MOTHER'S MAIDEN NAME <u>Eliza Faulkner</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If year, give war or dates of service) <u>None</u>	
16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Roger Vincent, Pocomoke, Md.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) <u>Cancer of the Bladder</u>	<u>Unknown</u>
181X Antecedent cause(s)	(b) <u>Old age</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) <u>Malnutrition</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar. 25, 1951, to Mar. 28, 1951, that I last saw the deceased alive on March 28, 1951, and that death occurred at 1:35 p.m., from the causes and on the date stated above.

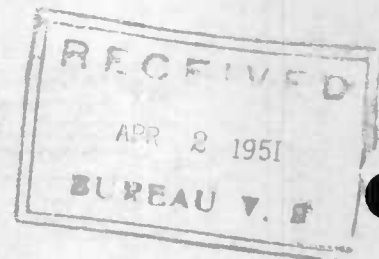
SIGNATURE Charles W. Trader, MD ADDRESS Pocomoke City, Md. DATE SIGNED Mar. 29, 1951

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/30/51</u>	<u>Bethany ME Cemetery</u>	<u>Pocomoke, Md.</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>March 30, 1951</u>	<u>Anne E. White</u>	<u>Henry H. Watson</u>	<u>Pocomoke, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

03151

Reg. Dist. No. 350

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pocomoke</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Laurel St.</u>		STREET ADDRESS (If rural, give location) <u>Laurel St.</u>	
3. NAME OF DECEASED (First) <u>H.</u> (Middle) <u>MERRILL</u> (Last) <u>WALTERS</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>13</u> (Year) <u>1951</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Feb 20, 1891</u>
9. AGE last birthday <u>60</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Insurance</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>William H. Walters</u>		14. MOTHER'S MAIDEN NAME <u>Annie Merrill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Henry P. Walters, Pocomoke, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260x Immediate cause (a) <u>Cerebral Hemorrhage</u>	<u>24 hours</u>	
Antecedent cause(s) (b) <u>Diabetes Mellitus</u>	<u>Many years</u>	
61 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Hypertension</u>	<u>1 year</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Chronic Nephritis, Chronic Coronary Heart Disease, Arteriosclerosis, Generalized.</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb., 1949, to Mar. 13, 1951, that I last saw the deceased alive on Mar. 13, 1951, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) Charles W. Trader, A.B., M.D. ADDRESS Pocomoke City Md. DATE SIGNED Mar. 14, 1951.

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cemetery</u>	LOCATION (City, town, or county) <u>Pocomoke, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>March 15, 1951</u>	REGISTRAR'S SIGNATURE <u>Anne E. White</u>	24. FUNERAL DIRECTOR <u>Henry H. Watson</u>	ADDRESS <u>Pocomoke, Md.</u>	

450 736

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
MAR 18 1951
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

03152

Reg. Dist. No. 355

1. PLACE OF DEATH - COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Worcester</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Flower St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Virginia</u> (First) (Middle) (Last) <u>Williams</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>3</u> <u>12</u> <u>1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Caucasian</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1924</u> 27 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housemaid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>General</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edw and William</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or date of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Bessie Johnson Berlin Md</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
982x Immediate cause (a) <u>Stab wound - left neck</u>	<u>min.</u>
Antecedent cause(s) (b) <u>Puncture wound - left internal jugular vein min.</u>	
167 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Multiple incised wounds - face & scalp</u>	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Argument over a "date"</u>		
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY FOR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>	PLACE (Home, farm, factory, street, or office, etc.) <u>Prison Camp</u>	CITY OR TOWN (COUNTY) (STATE) <u>Berlin</u> <u>Wor. Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3</u> <u>12</u> <u>51</u> <u>10</u> p.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Multiple stab wounds - Argument</u>

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☒, undetermined ☐.

SIGNATURE (Degree or title) <u>Dr. Sevaesche M.D. D.M.E.</u>		DATE SIGNED <u>3/13/51</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/15/51</u>	NAME OF CEMETERY OR CREMATORY <u>St Pauls (Cof)</u>	LOCATION (City, town, or county) (State) <u>Berlin</u> <u>Md</u>
DATE REC'D BY LOCAL REG <u>Mar 15, 1951</u>	REGISTRAR'S SIGNATURE <u>Helen F Hayward</u>	24. FUNERAL DIRECTOR <u>Anna A. Buehler</u>	ADDRESS <u>Berlin Md</u>

720836

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 18 1961
BUREAU A. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

03153

CERTIFICATE OF DEATH

Reg. Dist. No. 355

1. PLACE OF DEATH- COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Wor.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Whaleyville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>no number</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Sallie</u> (Middle) <u>Dale</u> (Last) <u>Wimbrow</u>	4. DATE OF DEATH (Month) <u>March</u> (Day) <u>22</u> (Year) <u>1951</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>10/17/1873</u>
9. AGE last birthday <u>77</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Whaleyville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Peter Dale</u>		14. MOTHER'S MAIDEN NAME <u>Jennie Mumford</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>N. J. Wimbrow St. Whaleyville, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Acute myocarditis

Antecedent cause(s)

(b)

Hypertension

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While at Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/15, 1951, to 3/22, 1951, that I last saw the deceased alive on 3/22, 1951, and that death occurred at 12:30 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3/23/51

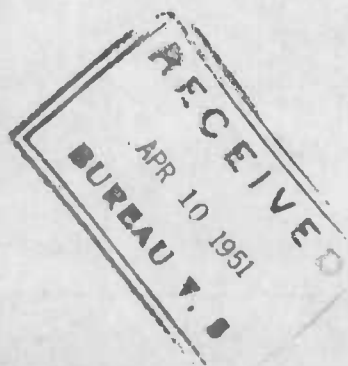
Helen A. Hayward

M. Pasha Watson Sillyville, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

03154

Reg. Dist. No. 350

1. PLACE OF DEATH - COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Va</u> COUNTY <u>Accomack</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>New Church, Va Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>New Church, Va Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Highway Route 13</u>		STREET ADDRESS (If rural give location) <u>None</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Harvey</u> (Middle) <u>Edward</u> (Last) <u>Young</u>	4. DATE OF DEATH	(Month) <u>3</u> (Day) <u>10</u> (Year) <u>1957</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Jan 9 - 1927</u> 24 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. Kind of BUSINESS OR INDUSTRY <u>Lumber mill</u>	11. BIRTHPLACE (State or foreign country) <u>Accomack, Va</u>
13. FATHER'S NAME <u>Thomas Young</u>		14. MOTHER'S MAIDEN NAME <u>Addie Allen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WWII</u>		16. SOCIAL SECURITY No. <u>220 263079</u>	17. INFORMANT <u>Addie Allen Young Parthen</u>
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Fractures of Skull</u>			<u>Immediate</u>
(b) Antecedent cause(s) <u>Head on - Auto Collision with a truck</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Deceased had been drinking</u>			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or other place, etc.) <u>Head on collision with a truck</u>	CITY OR TOWN <u>Pocomoke City</u> (COUNTY) <u>Worcester</u> (STATE) <u>Md</u>	
TIME (Month) (Day) (Year) (Hour) <u>Mar 10 1957</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Head on collision with a large truck</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Dr. M. C. Anthony</u>		DATE SIGNED <u>3/10/57</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3-18-57</u>	NAME OF CEMETERY OR CREMATORY <u>Accomack</u>	LOCATION (City, town, or county) <u>Accomack</u> (State) <u>Va.</u>
DATE REC'D BY LOCAL REG. <u>March 13, 1957</u>	REGISTRAR'S SIGNATURE <u>Anne E. White</u>	24. FUNERAL DIRECTOR <u>Edgar K. Whitton - New Church, Va.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

